104TH CONGRESS, 1st Session | HOUSE OF REPRESENTATIVES | REPORT 104–398

FEDERALLY SUPPORTED HEALTH CENTERS ASSISTANCE ACT OF 1995

DECEMBER 12, 1995.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BLILEY, from the Committee on Commerce, submitted the following

R E P O R T

[To accompany H.R. 1747]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 1747) to amend the Public Health Service Act to permanently extend and clarify malpractice coverage for health centers, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

CONTENTS

The amendments are as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; REFERENCES.

(a) SHORT TITLE.—This Act may be cited as the "Federally Supported Health Centers Assistance Act of 1995".

(b) REFERENCES.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

SEC. 2. EXTENSION OF PROGRAM.

(a) IN GENERAL.—Section 224(g)(3) (42 U.S.C. 233(g)(3)) is amended in the last sentence by striking "January 1, 1996" and inserting "January 1, 1999".

(b) CONFORMING AMENDMENTS.—Section 224(k) (42 U.S.C. 233(k)) is amended—

(1) in paragraph (1)(A), by striking "each of the fiscal years 1993, 1994, and 1995" and inserting "each of the fiscal years 1996 through 1998"; and

(2) in paragraph (2), by striking "each of the fiscal years 1993, 1994, and 1995" and inserting "each of the fiscal years 1996 through 1998".

SEC. 3. CLARIFICATION OF COVERAGE.

Section 224(g)(1) (42 U.S.C. 233(g)(1)) is amended—

(1) in the first sentence, by striking "officer, employee, or contractor" and inserting "officer, governing board member, or employee of such an entity, and any contractor"; and

(2) in the second sentence, by inserting after "officer," the following "governing board member,".

SEC. 4. COVERAGE FOR SERVICES FURNISHED TO INDIVIDUALS OTHER THAN CENTER PATIENTS.

Section 224(g)(1) (42 U.S.C. 233(g)) is amended—

(1) by redesignating paragraph (1) as paragraph (1)(A); and

(2) by adding at the end thereof the following:

"(B) The deeming of any entity or officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Service under subparagraph (A) shall apply with respect to services provided—

"(i) to all patients of the entity, and

"(ii) subject to subparagraph (C), to individuals who are not patients of the entity.

"(C) Subparagraph (B)(ii) applies to services provided to individuals who are not patients of an entity if the Secretary determines, after reviewing an application submitted under subparagraph (D), that the provision of the services to such individuals—

"(i) benefits patients of the entity and general populations that could be served by the entity through community-wide intervention efforts within the communities served by such entity;

"(ii) facilitates the provision of services to patients of the entity; or

"(iii) are otherwise required under an employment contract (or similar arrangement) between the entity and an officer, governing board member, employee, or contractor of the entity.".

SEC. 5. APPLICATION PROCESS.

(a) APPLICATION REQUIREMENT.—Section 224(g)(1) (42 U.S.C. 233(g)(1)) (as amended by section 4) is further amended—

(1) in subparagraph (A), by inserting "and subject to the approval by the Secretary of an application under subparagraph (D)" after "For purposes of this section"; and

(2) by adding at the end thereof the following:

"(D) The Secretary may not deem an entity or an officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Service under subparagraph (A), and may not apply such deeming to services described in subparagraph (B)(ii), unless the entity has submitted an application for such deeming to the Secretary in such form and such manner as the Secretary shall prescribe. The application shall contain detailed information, along with supporting documentation, to verify that the entity, and the officer, governing board member, employee, or contractor of the entity, as the case may be, meets the requirements of subparagraphs (B) and (C) of this paragraph and that the entity meets the requirements of paragraphs (1) through (4) of subsection (h).

"(E) The Secretary shall make a determination of whether an entity or an officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section within 30 days after the receipt of an application under subparagraph (D). The determination of the Secretary that an entity or an officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section shall apply for the period specified by the Secretary under subparagraph (A).

"(F) Once the Secretary makes a determination that an entity or an officer, governing board member, employee, or contractor of an entity is deemed to be an employee of the Public Health Service for purposes of this section, the determination shall be final and binding upon the Secretary and the Attorney General and other parties to any civil action or proceeding. Except as provided in subsection (i), the Secretary and the Attorney General may not determine that the provision of services which are the subject of such a determination are not covered under this section.".

(b) APPROVAL PROCESS.—Section 224(h) (42 U.S.C. 233(h)) is amended—

(1) in the matter preceding paragraph (1), by striking "Notwithstanding" and all that follows through "entity—" and inserting the following: "The Secretary may not approve an application under subsection (g)(1)(D) unless the Secretary determines that the entity—"; and

(2) by striking "has fully cooperated" in paragraph (4) and inserting "will fully cooperate".

SEC. 6. TIMELY RESPONSE TO FILING OF ACTION OR PROCEEDING.

Section 224 (42 U.S.C. 233) is amended by adding at the end thereof the following subsection:

"(l)(1) If a civil action or proceeding is filed in a State court against any entity described in subsection (g)(4) or any officer, governing board member, employee, or any contractor of such an entity for damages described in subsection (a), the Attorney General, within 15 days after being notified of such filing, shall make an appearance in such court and advise such court as to whether the Secretary has determined under subsections (g) and (h), that such entity, officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section with respect to the actions or omissions that are the subject of such civil action or proceeding. Such advice shall be deemed to satisfy the provisions of subsection (c) that the Attorney General certify that an entity, officer, governing board member, employee, or contractor of the entity was acting within the scope of their employment or responsibility.

"(2) If the Attorney General fails to appear in State court within the time period prescribed under paragraph (1), upon petition of any entity or officer, governing board member, employee, or contractor of the entity named, the civil action or proceeding shall be removed to the appropriate United States district court. The civil action or proceeding shall be stayed in such court until such court conducts a hearing, and makes a determination, as to the appropriate forum or procedure for the assertion of the claim for damages described in subsection (a) and issues an order consistent with such determination.".

SEC. 7. APPLICATION OF COVERAGE TO MANAGED CARE PLANS.

Section 224 (42 U.S.C. 223) (as amended by section 6) is amended by adding at the end thereof the following subsection:

"(m)(1) An entity or officer, governing board member, employee, or contractor of an entity described in subsection (g)(1) shall, for purposes of this section, be deemed to be an employee of the Public Health Service with respect to services provided to individuals who are enrollees of a managed care plan if the entity contracts with such managed care plan for the provision of services.

"(2) Each managed care plan which enters into a contract with an entity described in subsection (g)(4) shall deem the entity and any officer, governing board member, employee, or contractor of the entity as meeting whatever malpractice coverage requirements such plan may require of contracting providers for a calendar year if such entity or officer, governing board member, employee, or contractor of the entity has been deemed to be an employee of the Public Health Service for purposes of this section for such calendar year. Any plan which is found by the Secretary on the record, after notice and an opportunity for a full and fair hearing, to have violated this subsection shall upon such finding cease, for a period to be determined by the Secretary, to receive and to be eligible to receive any Federal funds under titles XVIII or XIX of the Social Security Act.

"(3) For purposes of this subsection, the term 'managed care plan' shall mean health maintenance organizations and similar entities that contract at-risk with

payors for the provision of health services or plan enrollees and which contract with providers (such as entities described in subsection (g)(4)) for the delivery of such services to plan enrollees.''.

SEC. 8. COVERAGE FOR PART-TIME PROVIDERS UNDER CONTRACTS.

Section 224(g)(5)(B) (42 U.S.C. 223(g)(5)(B)) is amended to read as follows:

''(B) in the case of an individual who normally performs an average of less than 32½ hours of services per week for the entity for the period of the contract, the individual is a licensed or certified provider of services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.''.

SEC. 9. DUE PROCESS FOR LOSS OF COVERAGE.

Section 224(i)(1) (42 U.S.C. 233(i)(1)) is amended by striking ''may determine, after notice and opportunity for a hearing'' and inserting ''may on the record determine, after notice and opportunity for a full and fair hearing''.

SEC. 10. AMOUNT OF RESERVE FUND.

Section 224(k)(2) (42 U.S.C. 223(k)(2)) is amended by striking ''$30,000,000'' and inserting ''$10,000,000''.

SEC. 11. REPORT ON RISK EXPOSURE OF COVERED ENTITIES.

Section 224 (as amended by section 7) is amended by adding at the end thereof the following subsection:

''(n)(1) Not later than April 1, 1997, the Secretary, in consultation with the Attorney General, shall submit to the Congress a report on the medical malpractice liability claims experience of entities that have been deemed to be employees for purposes of this section, and the risk exposure associated with such entities.

''(2) The report under paragraph (1) shall include an analysis by the Secretary comparing—

''(A) the Secretary's estimate of the aggregate amounts that such entities (together with the officers, governing board members, employees, and contractors of such entities who have been deemed to be employees for purposes of this section) would have directly or indirectly paid to obtain medical malpractice liability insurance coverage if this section were not in effect; with

''(B) the aggregate amounts by which the grants received by such entities under this Act were reduced pursuant to subsection (k)(2).

''(3) In preparing the report under paragraph (1), the Secretary shall consult with public and private entities with expertise on the matters with which the report is concerned.''.

Amend the title so as to read:

A bill to amend the Public Health Service Act to extend and clarify malpractice coverage for health centers, and for other purposes.

PURPOSE AND SUMMARY

Under section 224 of the Public Health Service Act, community, migrant, and homeless health centers are eligible for coverage for medical malpractice under the Federal Tort Claims Act (FTCA). Health centers were brought under the FCTA in 1993 by the Federally Supported Health Centers Assistance Act of 1992 (Public Law 102–501). Health centers and their employees, officers, and contractors are covered for malpractice claims in the same manner as employees of the Public Health Service who provide medical care. Section 224 of the Public Health Service Act provides this coverage for a three-year period, which expires December 31, 1995. During this period, FTCA coverage for health centers has only been partially implemented. Final regulations were issued only recently on May 8, 1995. Additional clarifications of coverage were issued by the Department of Health and Human Services in a Federal Register notice dated September 25, 1995.

H.R. 1747 would extend the FTCA coverage program for health centers for another three year period, through December 31, 1998.

The bill also makes clarifications in scope of coverage provided under the law. H.R. 1747 clarifies that malpractice coverage under the FTCA applies to all employees, officers, and governing board members of a health center, as well as to contractors of health centers who are licensed or certified health care practitioners. The bill also codifies provisions of the final regulations which clarify the application of FTCA malpractice coverage to health services provided in certain situations when health care clinicians are treating patients who are not registered with the health center. For example, health center clinicians participating in a community-wide immunization fair will have FTCA coverage when providing immunizations. Finally, the bill provides for coverage under FTCA of part-time health center clinicians who practice in the primary care areas of family practice, general internal medicine, general pediatrics, and obstetrics and gynecology.

H.R. 1747 also makes several procedural modifications to current law to improve the efficiency of the operation of the program. The bill establishes procedures for health centers to apply to the Department of Health and Human Services and receive approval for malpractice coverage under FTCA.

Finally, the bill recognizes the movement of the health care market toward managed care and the increased participation by health centers as providers in managed care plans. H.R. 1747 applies FTCA coverage to health services provided by centers to enrollees of managed care plans who have chosen the health center as their provider. The bill also establishes that FTCA coverage is to be accepted by managed care plans as meeting the requirements for malpractice coverage for health centers who contract to be providers for managed care plans.

BACKGROUND AND NEED FOR LEGISLATION

The Federal government makes primary health care services available to medically underserved populations through four programs: the Community Health Center program (section 330 of the Public Health Service (PHS) Act); the Migrant Health program (section 329 of the PHS Act); the Health Care for the Homeless program (section 340 of the PHS Act); and the Health Services for Residents of Public Housing program (section 340A of the PHS Act). In each program, the Department of Health and Human Services (HHS) makes grants to public or private nonprofit entities to provide primary health care services to specified underserved populations, regardless of their ability to pay. In Fiscal Year 1995, $756.5 million will be used to provide primary and preventive health services to approximately 7.6 million people through community, migrant, homeless, and public housing health centers.

To provide health care services, the grantees (and subcontracting organizations) employ physicians and other health care practitioners either directly or on a contract basis. Purchase of malpractice insurance is one of the most significant expenses for health centers. In 1992, the Committee examined health center expenses for malpractice insurance and found, based on data provided by HHS and others, that over $50 million had been spent in Fiscal Year 1989 for malpractice insurance premiums; less than 10 percent of that amount had been paid out in actual claims payments and related

costs. The Bureau of Primary Health Care at HHS estimates that in 1994, health centers spent just under $50 million for malpractice insurance premiums. Grant funds continue to be used to pay a large percentage of these premium costs—funds that otherwise could be used for patient care.

At the time the Committee first began to examine this issue, health clinics operated by tribes and tribal organizations under contracts with the Indian Health Service pursuant to the Indian Self-Determination Act had been afforded the protection of the FTCA for malpractice for five years. In addition, National Health Service Corps physicians, who provide much of the staffing for health centers, also were covered under the FTCA. Based on the similarity of health center experience to the tribal clinics and the National Health Service Corps, as well as the low malpractice claim rates experienced by health centers, Congress enacted Public Law 102–501, extending malpractice coverage under the FTCA to health centers for a three-year period, ending December 31, 1995.

To date, P.L. 102–501 has been implemented only partially. Final regulations were issued on May 8, 1995, with additional clarifications issued in a September 19, 1995, Policy Information Notice and a September 25, 1995, Federal Register notice. The lengthy period of uncertainty regarding the law's scope made it necessary for many health centers to continue their private malpractice coverage. To date, 542 health centers have been "deemed" by HHS as eligible for malpractice coverage under FTCA, and 119 health centers have dropped private malpractice coverage for one or more of their clinicians. Twenty-nine percent of health center clinicians currently are covered by FTCA. The Committee expects that the enactment of this legislation extending the program, clarifying coverage, and improving procedures, along with continued efforts by the Department to implement the legislation, will lead many more health centers to drop their private malpractice coverage and participate fully in the program.

The program has yielded significant savings for participating health centers. For example, Roderick Manifold, the Executive Director of Central Virginia Health Services in New Canton, Virginia, estimates that, due to the FTCA program, the center is saving $90,000 annually that otherwise would be expended by the center on malpractice insurance premiums. These funds are being redirected to patient care. Another health center generating savings from the program is Monway Family Health Center in Carlton, Michigan, which is saving over $14,000 annually. The National Association of Community Health Centers estimates that over the past two and one half years, over $14.3 million in malpractice insurance costs have been saved and used to provide care for an additional 75,000 patients.

The number of medical malpractice claims against health centers under FTCA has been very low. To date, only 15 claims have been approved for FTCA coverage. This low number is consistent with the low rate of claims filed against health centers under private insurance. A total of $11 million of health center appropriations has been set aside over the last three years for FTCA judgment costs. None of these funds have been obligated or expended thus far. An-

other $5 million is anticipated to be transferred to the judgment fund from health center appropriations for Fiscal Year 1996.

The Committee's review of the initial experience under this program revealed that several factors have served as disincentives for full health center participation in the program. In particular, there was uncertainty over the scope of FTCA coverage under the program, which the Committee bill seeks to clarify in two ways. First, the bill makes clear that malpractice coverage under FTCA is provided to a health center and all its employees, officers, and governing board members, both health professionals and others. In the case of contractors providing health services to health center patients, coverage is provided only to contractors who are licensed or certified health care practitioners.

Second, the bill codifies provisions of the May 8, 1995, final regulations which state that malpractice coverage will be provided under FTCA for acts and omissions related to the grant-supported activity of the health center and describe the conditions under which health center practitioners are covered for services to individuals who are not registered patients of the health center. In its September 25, 1995, Federal Register notice, HHS provided example of such situations which include health fairs, immunization campaigns, outreach and screening at migrant camps and homeless shelters, periodic hospital call or emergency room coverage required for obtaining hospital admitting privileges, and cross-coverage arrangements with other community providers. The Committee intends that those situations continue to be recognized as being within the scope of coverage.

The Committee is concerned about the length of time that it has taken for malpractice claims to be processed. When a claim is filed against a health center, the Department of Justice (DOJ) requests the health center's application for FTCA coverage from HHS and often has requested additional supporting documentation from the health center concerning the items described in the application. The examination of this documentation after a claim is filed, rather than when the application for coverage is approved, has resulted in delays in the appearance by DOJ in State or local court. This has resulted in at least one default judgment against a health center involving a claim that later was determined to be covered under the FTCA. H.R. 1747 remedies this problem by establishing a procedure in which a health center files a formal application for FTCA coverage containing all supporting documentation. The application also will detail the situations in which health center practitioners treating non-registered patients of the center would be covered. The Committee believes that having health centers provide this documentation in advance will enhance greatly the ability of HHS and DOJ to respond when a malpractice claim is filed against a health center.

Some concerns have been raised that insufficient data exists to support the permanent extension of malpractice coverage for health centers under the FTCA. In an effort to generate additional data concerning the program, H.R. 1747 requires the Secretary of HHS, in consultation with the Attorney General, to submit to the Congress a report on the medical malpractice liability claims experience of health centers covered under FTCA and the risk exposure

associated with the coverage of health centers. In preparing the report, the Secretary will consult with public and private entities with expertise in this area. The Committee believes that the report will generate sufficient data to eliminate any remaining concerns about the cost-effectiveness of the program.

HEARINGS

The Committee on Commerce has not held hearings on the legislation.

COMMITTEE CONSIDERATION

On September 27, 1995, the Committee on Commerce met in open markup session and ordered H.R. 1747 reported to the House, as amended, by voice vote, a quorum being present.

ROLLCALL VOTES

Clause 2(l)(2)(B) of rule XI of the Rules of the House requires the Committee to list the recorded votes on the motion to report legislation and on amendments thereto. There were no recorded votes taken in connection with ordering H.R. 1747 reported or in adopting the amendment. The voice votes taken in Committee are as follows:

Bill: H.R. 1747, Federally Supported Health Centers Assistance Act of 1995.

Amendment: Amendment by Mr. Bilirakis re: extend the program for three years, rather than permanently.

Disposition: Agreed to, by a voice vote.

Motion: Motion by Mr. Bliley to order H.R. 1747, as amended, reported to the House.

Disposition: Agreed to, by a voice vote.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this legislation.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee states that H.R. 1747 would result in no new or increased budget authority or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, following is the cost estimate provided by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS
CONGRESSIONAL BUDGET OFFICE,
Washington, DC December 11, 1995.

Hon. THOMAS J. BLILEY, Jr.,
Chairman, Committee on Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 1747, a bill to reauthorize malpractice coverage under the Federal Tort Claims Act (FTCA) for employees of federally-supported health centers, as ordered reported by the House Committee on Commerce on September 27, 1995. Pay-as-you-go procedures would not apply because the bill would not affect direct spending.

Under the Federally Supported Health Centers Assistance Act of 1992, the Secretary of Health and Human Services may deem full-time providers and select part-time contractors at federally-supported health centers to be employees of the Public Health Service. As such, these providers are eligible for malpractice coverage under FTCA for services rendered within the scope of their contract or the center's grant. Any malpractice claims filed against these providers are defended by the Justice Department and are heard in U.S. District Court.

At the start of each fiscal year, the Attorney General estimates the dollar amount of malpractice claims expected to arise in that year and transfers this amount into a reserve fund; judgments are paid out of this fund. Eligible centers and employees are covered under FTCA only in years in which this money transfer occurs. Current law limits the annual amount of these transfers to $30 million, although balances in the fund remain available for obligation in later years. If the dollar value of claims filed in a given year surpasses the amount in the reserve fund, any remaining claims are paid out of the claims and judgments fund.

H.R. 1747 would reauthorize the Federally Supported Health Centers Assistance Act through 1998, with some modifications to the program. The proposal would cap the amount the Attorney General could transfer into the reserve fund at $10 million a year. It would also extend malpractice coverage to employees of managed care organizations that have contracts to care for centers' patients. Additionally, the bill would offer coverage to part-time contract providers in the fields of general internal medicine, general pediatrics, family practice or obstetrics and gynecology. Finally, H.R. 1747 would, under certain circumstances, over deemed employees for services rendered to individuals who are not health center patients.

Lags in the filing of malpractice claims and in the settlement process make it difficult to estimate the dollar value of claims incurred per fiscal year. Based on current claims data, however, CBO believes that $10 million annual transfer to the reserve fund would be sufficient to cover claims that would arise from incidents in a fiscal year. This estimate is based that the assumption that health centers' participation in the program remains at its current rate of 20 percent; if more health centers were to participate, the funds provided under the proposal might not be sufficient. Additionally, costs would likely increase if the program's authorization was extended for a longer period.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Anne Hunt.

Sincerely,

JUNE E. O'NEILL, *Director.*

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that H.R. 1747 would have no inflationary impact.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act are created by this legislation.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title; reference

Section 1 states that the short title of the bill is the Federally Supported Health Centers Assistance Act of 1995.

Section 1 also provides that, unless otherwise expressly provided, all references are to the Public Health Service Act.

Section 2. Extension of program

Under current law (section 224 of the Public Health Service Act), certain Federally assisted health centers, and their physicians and other health care practitioners, are covered for malpractice claims under the Federal Tort Claims Act (FTCA) (28 U.S.C. sections 1346(b) and 2671–2680) in the same manner as are employees of the Public Health Service who provide medical care. The law provides this coverage for a three-year period, which expires December 31, 1995.

Section 2 extends the period of coverage through December 31, 1998. This section also revises other references to the period of coverage in section 224(k) to conform to the revised termination date of December 31, 1998.

Section 3. Clarification of coverage

Under current law, FTCA coverage is extended to officers, employees, and certain contracting physicians of the covered health centers. The bill would extend coverage to governing board members of the covered health centers as well and would clarify that

all officers, employees, and governing board members would receive FTCA coverage whether or not they are health care practitioners.

Section 4. Coverage for services furnished to individuals other than center patients

On May 8, 1995, final regulations were published (60 FR 22530), clarifying that FTCA coverage would apply with respect to services provided not only to all patients of the covered health centers, but also to individuals who are not patients if the Secretary determines, after reviewing an application submitted by a covered health center, that the provision of such services: (i) benefits patients of the health center and general populations that could be served by the health center through community-wide intervention efforts within the communities served by such center; (ii) facilitates the provision of services to patients of the health center; or (iii) is otherwise required under an employment contract (or similar arrangement) between the health center and an officer, governing board member, employee, or contractor of the health center. For example, health center clinicians participating in a community-wide immunization fair will have FTCA coverage when providing immunizations.

Section 4 of the bill adds to section 224(g) of the Public Health Service Act the clarifying language of the final regulation regarding the scope of FTCA coverage.

Section 5. Application process

Under current law, FTCA coverage is not effective for an eligible health center or its personnel until the Secretary has determined that the center meets the requirements of section 224(h) regarding appropriate policies and procedures to reduce the risk of malpractice, including review and verification of professional credentials; claims history; licensure status of physicians and other health care practitioners; and cooperation with the Attorney General in matters relating to any malpractice claims or claims history.

Section 5 establishes a process by which each eligible health center that desires coverage under the FTCA must submit an application in such form and containing such information as the Secretary shall prescribe to determine that the health center meets the requirements of subsections 224(g) and 224(h). The bill stipulates that the Secretary shall make such a determination within 30 days after receipt of a health center's application, and that the determination shall apply for a period specified by the Secretary. Once the Secretary makes a determination that a health center and its personnel are covered under the FTCA, the determination shall be final and binding on the Secretary and the Attorney General and other parties to any civil action or proceeding, and shall apply to all services which are the subject of such a determination.

Section 6. Timely response to filing of action or proceeding

Under current law, the Attorney General is responsible for securing the removal to Federal Court of any civil action or proceeding filed in a State or local court against a health center or individual covered under the FTCA. However, current law contains no provision concerning the timeliness of such a response by the Attorney

General. If the response is not timely, a default judgment against the defendant health center or individual could be filed.

Section 6 includes a provision requiring that, if a civil action or proceeding is filed in a State or local court against any covered health center or its covered personnel, the Attorney General, within 15 days after being notified of such filing, shall make an appearance in such court and advise such court as to whether the defendant health center or individual is covered under the FTCA with respect to the actions or omissions that are the subject of such civil action or proceeding. Further, if the Attorney General fails to appear within the specified time period, upon the petition of the covered health center or its covered personnel, the civil action or proceeding shall be removed to the appropriate United States district court, and the civil action or proceeding shall not be acted on until a hearing is conducted and a determination is made as to the appropriate forum or procedure for the assertion of the claim for damages.

Section 7. Application of coverage to managed care plans

Section 7 of the bill clarifies that coverage under the FTCA for health centers and their personnel applies with respect to services provided to individuals who are enrollees of a managed care plan if the covered health center contracts with such managed care plan for the provision of services. Under the bill, each managed care plan which enters into a contract with a covered health center is required to accept coverage under the FTCA as meeting whatever malpractice coverage requirements it may require of contracting providers. Any managed care plan which is found by the Secretary on the record, after notice and an opportunity for a full and fair hearing, to have violated this requirement shall, upon such finding, cease, for a period to be determined by the Secretary, to be eligible to receive any Federal funds under title XVIII or XIX of the Social Security Act. The bill defines the term 'managed care plan' as meaning health maintenance organizations and similar entities that contract at-risk with payors for the provision of health services to plan enrollees and which contract with providers (such as the health centers described in this subsection) for the delivery of such services to its enrollees.

Section 8. Coverage for part-time providers under contracts

Under current law, FTCA coverage extends to licensed or certified providers who contract with a covered health center if they perform on average at least 32½ hours of service per week for the health center for the period of their contract. Contractors who perform fewer than 32½ hours of service per week are also covered if they are licensed or certified providers of obstetrical services and either (1) their medical malpractice liability coverage does not extend to the services they perform for the covered health centers or (2) the Secretary finds that patients of the covered health center will be deprived of obstetrical services if the contractors are not covered under the FTCA.

Section 8 revises the latter provision. Individuals who normally perform an average of fewer than 32½ hours of services per week for a covered health center will be covered under the FTCA if they

are licensed or certified providers of services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

Section 9. Due process for loss of coverage

Current law authorizes the Attorney General, in consultation with the Secretary, to deny FTCA coverage to an individual physician or other licensed or certified health care practitioner if the Attorney General determines that extending FTCA coverage to the individual would expose the U.S. government to an unreasonably high degree of risk of loss. The bill would ensure due process in any such action by stipulating that any denial or removal of FTCA coverage must be made on the record, after notice and an opportunity for a full and fair hearing.

Section 10. Amount of reserve fund

Under current law, FTCA coverage for health centers shall be effective in a fiscal year only if the Secretary has transferred to the judgment fund sufficient funds to meet the cost of any judgments against the U.S. government and related fees, as estimated by the Attorney General in consultation with the Secretary. The law limits the amount of a transfer to not more than $30 million in any fiscal year. For Fiscal Years 1994 and 1995, the Congress has limited the amount of this transfer to not more than $5 million for each fiscal year.

Section 10 would revise the maximum amount to be transferred in any fiscal year to not more than $10 million.

Section 11. Report on risk exposure of covered entities

Section 11 adds a new subsection 224(n) to the PHS Act, which requires the Secretary, in consultation with the Attorney General, to submit by April 1, 1997, a report to the Congress on the malpractice liability claims experience of health centers covered under the FTCA and the risk exposure associated with that coverage. The report must include an analysis comparing the Secretary's estimate of the amount that the covered health centers and their covered personnel would have paid to obtain private malpractice insurance coverage, if this section were not in effect, with the aggregate amounts that were transferred by the Secretary to this judgment fund over the same period. In preparing this report, the Secretary is expected to consult with public and private entities with expertise in matters covered in the report.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 224 OF THE PUBLIC HEALTH SERVICE ACT

DEFENSE OF CERTAIN MALPRACTICE AND NEGLIGENCE SUITS

SEC. 224. (a) * * *

* * * * * * *

(g)(1)*(A)* For purposes of this section *and subject to the approval by the Secretary of an application under subparagraph (D),* an entity described in paragraph (4) and any ⟦officer, employee, or contractor⟧ *officer, governing board member, or employee of such an entity, and any contractor* (subject to paragraph (5)) of such an entity who is a physician or other licensed or certified health care practitioner shall be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer of the full amount estimated under subsection (k)(1)(A) was made under subsection (k)(3) (subject to paragraph (3)). The remedy against the United States for an entity described in paragraph (4) and any officer, *governing board member,* employee, or contractor (subject to paragraph (5)) of such an entity who is deemed to be an employee of the Public Health Service pursuant to this paragraph shall be exclusive of any other civil action or proceeding to the same extent as the remedy against the United States is exclusive pursuant to subsection (a).

(B) The deeming of any entity or officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Service under subparagraph (A) shall apply with respect to services provided—

(i) to all patients of the entity, and

(ii) subject to subparagraph (C), to individuals who are not patients of the entity.

(C) Subparagraph (B)(ii) applies to services provided to individuals who are not patients of an entity if the Secretary determines, after reviewing an application submitted under subparagraph (D), that the provision of the services to such individuals—

(i) benefits patients of the entity and general populations that could be served by the entity through community-wide intervention efforts within the communities served by such entity;

(ii) facilitates the provision of services to patients of the entity; or

(iii) are otherwise required under an employment contract (or similar arrangement) between the entity and an officer, governing board member, employee, or contractor of the entity.

(D) The Secretary may not deem an entity or an officer, governing board member, employee, or contractor of the entity to be an employee of the Public Health Service under subparagraph (A), and may not apply such deeming to services described in subparagraph (B)(ii), unless the entity has submitted an application for such deeming to the Secretary in such form and such manner as the Secretary shall prescribe. The application shall contain detailed information, along with supporting documentation, to verify that the entity, and the officer, governing board member, employee, or contractor of the entity, as the case may be, meets the requirements of subparagraphs (B) and (C) of this paragraph and that the entity meets the requirements of paragraphs (1) through (4) of subsection (h).

(E) The Secretary shall make a determination of whether an entity or an officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section within 30 days after the receipt of an application under subparagraph (D). The determination of the Secretary that an entity or an officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section shall apply for the period specified by the Secretary under subparagraph (A).

(F) Once the Secretary makes a determination that an entity or an officer, governing board member, employee, or contractor of an entity is deemed to be an employee of the Public Health Service for purposes of this section, the determination shall be final and binding upon the Secretary and the Attorney General and other parties to any civil action or proceeding. Except as provided in subsection (i), the Secretary and the Attorney General may not determine that the provision of services which are the subject of such a determination are not covered under this section.

* * * * * * *

(3) This subsection shall apply with respect to a cause of action arising from an act or omission which occurs on or after January 1, 1993. This subsection shall not apply with respect to a cause of action arising from an act or omission which occurs on or after January 1, **[**1996**]** *1999*.

* * * * * * *

(5) For purposes of paragraph (1), an individual may be considered a contractor of an entity described in paragraph (4) only if—

(A) the individual normally performs on average at least 32½ hours of service per week for the entity for the period of the contract; or

[(B) in the case of an individual who normally performs on average less than 32½ hours of services per week for the entity for the period of the contract and is a licensed or certified provider of obstetrical services—

[(i) the individual's medical malpractice liability insurance coverage does not extend to services performed by the individual for the entity under the contract, or

[(ii) the Secretary finds that patients to whom the entity furnishes services will be deprived of obstetrical services if such individual is not considered a contractor of the entity for purposes of paragraph (1).**]**

(B) in the case of an individual who normally performs an average of less than 32½ hours of services per week for the entity for the period of the contract, the individual is a licensed or certified provider of services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

* * * * * * *

(h) **[**Notwithstanding subsection (g)(1), the Secretary, in consultation with the Attorney General, may not deem an entity described in subsection (g)(4) to be an employee of the Public Health Service Act for purposes of this section unless the entity—**]** *The*

Secretary may not approve an application under subsection (g)(1)(D) unless the Secretary determines that the entity—

(1) * * * * * *

(4) [has fully cooperated] *will fully cooperate* with the Attorney General in providing information relating to an estimate described under subsection (k).

(i)(1) Notwithstanding subsection (g)(1), the Attorney General, in consultation with the Secretary, [may determine, after notice and opportunity for a hearing] *may on the record determine, after notice and opportunity for a full and fair hearing*, that an individual physician or other licensed or certified health care practitioner who is an officer, employee, or contractor of an entity described in subsection (g)(4) shall not be deemed to be an employee of the Public Health Service for purposes of this section, if treating such individual as such an employee would expose the Government to an unreasonably high degree of risk of loss because such individual—

(A) * * *

* * * * * * *

(k)(1)(A) For [each of the fiscal years 1993, 1994, and 1995] *each of the fiscal years 1996 through 1998*, the Attorney General, in consultation with the Secretary, shall estimate by the beginning of the year (except that an estimate shall be made for fiscal year 1993 by December 31, 1992, subject to an adjustment within 90 days thereafter) the amount of all claims which are expected to arise under this section (together with related fees and expenses of witnesses) for which payment is expected to be made in accordance with section 1346 and chapter 171 of title 28, United States Code, from the acts or omissions, during the calendar year that begins during that fiscal year, of entities described in subsection (g)(4) and of officers, employees, or contractors (subject to subsection (g)(5)) of such entities.

* * * * * * *

(2) Subject to appropriations, for [each of the fiscal years 1993, 1994, and 1995] *each of the fiscal years 1996 through 1998*, the Secretary shall establish a fund of an amount equal to the amount estimated under paragraph (1) that is attributable to entities receiving funds under each of the grant programs described in paragraph (4) of subsection (g), but not to exceed a total of [$30,000,000] *$10,000,000* for each such fiscal year. Appropriations for purposes of this paragraph shall be made separate from appropriations made for purposes of sections 329, 330, 340 and 340A.

(l)(1) If a civil action or proceeding is filed in a State court against any entity described in subsection (g)(4) or any officer, governing board member, employee, or any contractor of such an entity for damages described in subsection (a), the Attorney General, within 15 days after being notified of such filing, shall make an appearance in such court and advise such court as to whether the Secretary has determined under subsections (g) and (h), that such entity, officer, governing board member, employee, or contractor of the entity is deemed to be an employee of the Public Health Service for purposes of this section with respect to the actions or omissions that are the subject of such civil action or proceeding. Such advice shall be deemed to satisfy the provisions of subsection (c) that the Attor-

ney General certify that an entity, officer, governing board member, employee, or contractor of the entity was acting within the scope of their employment or responsibility.

(2) If the Attorney General fails to appear in State court within the time period prescribed under paragraph (1), upon petition of any entity or officer, governing board member, employee, or contractor of the entity named, the civil action or proceeding shall be removed to the appropriate United States district court. The civil action or proceeding shall be stayed in such court until such court conducts a hearing, and makes a determination, as to the appropriate forum or procedure for the assertion of the claim for damages described in subsection (a) and issues an order consistent with such determination.

(m)(1) An entity or officer, governing board member, employee, or contractor of an entity described in subsection (g)(1) shall, for purposes of this section, be deemed to be an employee of the Public Health Service with respect to services provided to individuals who are enrollees of a managed care plan if the entity contracts with such managed care plan for the provision of services.

(2) Each managed care plan which enters into a contract with an entity described in subsection (g)(4) shall deem the entity and any officer, governing board member, employee, or contractor of the entity as meeting whatever malpractice coverage requirements such plan may require of contracting providers for a calendar year if such entity or officer, governing board member, employee, or contractor of the entity has been deemed to be an employee of the Public Health Service for purposes of this section for such calendar year. Any plan which is found by the Secretary on the record, after notice and an opportunity for a full and fair hearing, to have violated this subsection shall upon such finding cease, for a period to be determined by the Secretary, to receive and to be eligible to receive any Federal funds under titles XVIII or XIX of the Social Security Act.

(3) For purposes of this subsection, the term ''managed care plan'' shall mean health maintenance organizations and similar entities that contract at-risk with payors for the provision of health services or plan enrollees and which contract with providers (such as entities described in subsection (g)(4)) for the delivery of such services to plan enrollees.

(n)(1) Not later than April 1, 1997, the Secretary, in consultation with the Attorney General, shall submit to the Congress a report on the medical malpractice liability claims experience of entities that have been deemed to be employees for purposes of this section, and the risk exposure associated with such entities.

(2) The report under paragraph (1) shall include an analysis by the Secretary comparing—

(A) the Secretary's estimate of the aggregate amounts that such entities (together with the officers, governing board members, employees, and contractors of such entities who have been deemed to be employees for purposes of this section) would have directly or indirectly paid to obtain medical malpractice liability insurance coverage if this section were not in effect; with

(B) the aggregate amounts by which the grants received by such entities under this Act were reduced pursuant to subsection (k)(2).

(3) In preparing the report under paragraph (1), the Secretary shall consult with public and private entities with expertise on the matters with which the report is concerned.

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